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Educational Interventions to Improve Nurses' and Nursing Students' Cultural Competence

- A Literature Review

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Abstract

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The purpose of this final project was to identify effective educational interventions designed to improve nurses' and nursing students' self-reported cultural competence and describe the outcome of these interventions. The knowledge gained from this literature review can be used to further develop and amplify the contents of cultural competence trainings and improve health care for ethnic minorities. Our final project was part of the Local and Global Development in Social Services and Health Care (LOG-Sote) project.

The final project consisted of a systematic literature review of 18 research articles, three literature reviews and one meta-analysis. All the articles were systematically collected from the databases CINAHL and MEDLINE or extracted manually from bibliographies and high quality nursing journals.

The findings indicated that cultural competence training is effective in increasing nurses´ and nursing students' self-reported cultural competence. 15 out of the 18 research articles indicated statistically significant improvements in the cultural competence levels reported by professional nurses and nursing students after the educational intervention. These findings were also supported by three literature reviews and one meta-analysis. The positive effect was present regardless of the training method. Effective training methods included cultural immersion programs, service-learning, class-room and online teaching, DVDs and other publications.

We found out that there are gaps in research evaluating the effects of nurses' and nursing' students cultural competence education from the patient outcome perspective.

Keywords	cultural competence, educational intervention, nurse, nursing student, cultural immersion

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Tämän opinnäytetyön tarkoituksena oli selvittää koulutusinterventioiden vaikuttavuutta sairaanhoitajien ja sairaanhoidon opiskelijoiden kulttuurisen osaamisen kehittymiseen. Opinnäytetyömme tuloksia voidaan hyödyntää koulutusinterventioiden sisältöjä suunniteltaessa. Hyvin suunniteltujen koulutusinterventioiden avulla voidaan vaikuttaa maahanmuuttajataustaisten asiakkaiden kokemaan hoidon laatuun sekä saatavuuteen, ja sitä kautta vähentää eri väestöryhmien välisiä terveyseroja. Opinnäytetyömme on osa LOG-Sote-kehityshanketta, jonka tavoitteena on parantaa maahanmuuttajien terveydenhoitoa kehittämällä ammatillista osaamista sekä hyviä käytänteitä.

Opinnäytetyömme toteutettiin systemaattisena kirjallisuuskatsauksena. Kirjallisuuskatsaukseen sisällytettiin 18 tutkimusta, kolme kirjallisuuskatsausta sekä yksi meta-analyysi. Aineisto kerättiin systemaattisena tietokantahakuna CINAHL ja MEDLINE tietokannoista. Lisäksi haimme soveltuvia tutkimuksia manuaalisesti tietokantahauilla löydettyjen tutkimusten lähdeluetteloista sekä akateemisista tutkimusjulkaisuista.

Tuloksista ilmeni, että sairaanhoitajien ja sairaanhoidon opiskelijoiden itsearvioitu kulttuurinen osaaminen kehittyi erilaisten koulutusinterventioiden seurauksena. Positiivinen muutos havaittiin 15:ssa tutkimuksessa. Tulokset olivat yhteneviä kolmen aikaisemman kirjallisuuskatsauksen sekä yhden meta-analyysin kanssa. Koulutusten vaikuttavuus ei näyttänyt riippuvan koulutuksessa käytetyistä opetusmetodeista, joita olivat muun muassa vaihto-ohjelmat, projektioppiminen, luentomuotoinen opetus, verkko-opetus sekä erilaiset itseopiskelumateriaalit, kuten videot sekä kirjalliset julkaisut.

Lisäksi tarvitaan jatkotutkimuksia sairaanhoitajien ja sairaanhoidon opiskelijoiden kulttuurisen osaamisen kehittämiseksi suunniteltujen koulutusten vaikutuksista monikulttuuristen potilaiden kokemaan hoidon laatuun sekä hoidon tuloksiin.

Avainsanat	kulttuurinen osaaminen, koulutusinterventio, sairaanhoitaja, sairaanhoidon opiskelija, kulttuurikylpy

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1 Introduction

The ethnic demography is constantly evolving and cultural diversity is increasing in the Finnish society. In 2011, the number of foreign citizens living permanently in Finland was 183.055, comprising of 177 different nationalities and still a total of 3.614 remaining stateless or unknown (Finnish Immigration Service statistics 2011). According to the Finnish Population Register Centre, during the past five years the number of foreign people living in Finland has grown by over 10.000 inhabitants per year (Taskutieto 2011). This multiplicity of various nationalities is changing Finland into a multicultural country and it is posing new challenges for the health care system. In order to minimize the health disparities related to cultural backgrounds of patients, health care professionals should improve their cultural competence. That can be defined for example "as the ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community)" (Campinha-Bacote 2002:181).

The need for multicultural knowledge and sensitivity in nursing can be justified by looking at the Code of Ethics adopted by the International Council for Nurses (2006:2). The code states in the first principal that "...the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected." The same idea can be also found in the Finnish Law, in the Act on the Status and Rights of Patients in the article No. 789/1992 (Finlex 1992), in which it is said that "...individual needs and culture of the patient have to be taken into account as far as possible in his/her care and other treatment." Requirement for nurses to carry out their practice in a culturally sensitive and knowledgeable manner emerges from the Universal declaration of human rights as well, which in the 25th article states that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control" (Universal declaration of human rights 1948). This basic human right is compromised by culturally incompetent care.

To meet the needs of diverse patients, educational interventions aimed for health professionals and nursing students have been suggested to be effective in increasing the knowledge and capability of addressing cultural issues (Brathwaite & Majumdar 2006:476-477; Hunter & Krantz 2010:210-211; Moffat & Tung 2004:62-63). Beach et al. (2005) conducted a systematic literature review of 34 intervention programs designed to improve the cultural competence of health care providers. According to their literature review cultural competence education does promote and enhance the cultural knowledge, attitudes and skills of health professionals. However, they found out that there is a lack of evidence that the cultural competence training would improve patient outcome and they suggested that future research should pay more attention to the effects of cultural competence training from a patient's point of view. The need for cultural competence education in Finland also came up in the doctoral thesis of Sainola-Rodriquez (2009:13), which states that every Finnish research article published between 1993 and 2008 and dealing with the health care and nursing of immigrants highlighted the need for further education about encounters with immigrant patients.

This final project targeted to respond to the needs of migrants and minority patients by searching evidence-based knowledge regarding the provision of training for health care professionals and nursing students in transcultural nursing context. The purpose of this literature review was to identify effective educational interventions designed to improve nurses' and nursing students' cultural competence and describe the outcome of these interventions. This final project was a part of the Local and Global Development in Social Services and Health Care (LOG-Sote) project.

2 Transcultural nursing background and key concepts

The key concepts linked to our final project are defined and discussed next. The key concepts are culture, multiculturalism, cultural competence, educational interventions and cultural competence assessment tools. This chapter also discusses the background of transcultural nursing and cultural competence models.

2.1 Transcultural nursing

Before 1950s the concepts of culture and care were not the focus of interest in nursing (Leininger & McFarland 2002:6), however, Florence Nightingale already touched the

concept of transcultural nursing in the 19th century when advising British nurses working in India to take into account the cultural background of the patients (Cowan & Norman 2006:84). But it was not until in the 1950s that Dr. Madeleine Leininger, a nurse-anthropologist, introduced transcultural nursing as a formal area of study and practice for nurses (Andrews & Boyle 2003:4). In order to provide the optimal, culturally appropriate care for patients today, the demand for nurses is different. Being able to respond to patients cultural needs is recognized as an ethical prerequisite in nursing. (Leininger & McFarland 2002:6.)

Leininger published a seminar work in 1970; Nursing and Anthropology: Two Worlds to Blend. Leininger's seminar work was the first attempt to combine the two worlds of anthropology and nursing into transcultural nursing. (Campinha-Bacote 2011:42.) Transcultural nursing is the comparative study and analysis of different cultures and subcultures in the context of nursing. Transcultural nursing research is interested in examining health and illness beliefs and values; patterns of behavior, caring behaviors and nursing care of different cultural groups. The goal of transcultural nursing research is to develop culture-specific and culture-universal knowledge to guide practical nursing care. (Andrews & Boyle 2003:4.) Creating relevant knowledge is germane for providing culturally competent and congruent nursing care and, thus, the ultimate goal of transcultural nursing according to Leininger (Giger & Davidhizar 2003:5).

2.2 Culture and multiculturalism

When encountering immigrant patients, health care professionals should have knowledge on the influence of culture in the care processes. The concept of culture has to be integrated in all aspects of nursing care. (Sainola-Rodriquez 2009:27.) There are multiple definitions for culture. Cross, Bazmn, Dennis & Isaacs (1989:7) define culture as the integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups. Culture can also be viewed as the "learned, shared, and transmitted knowledge of values, beliefs, and lifeways of a particular group that are generally transmitted intergenerationally and influence thinking, decisions, and actions in patterned of certain ways" (Leininger & McFarland 2002:47). Hall (1980:60) gives a broader definition to culture by saying, that it is "the study of relationships between

elements in a whole way of life", rather than the practice or a simple description of morals and modes of thinking in societies. Multiculturalism in health care refers to the dissimilarities brought on by patient's cultural, national and ethnical background as well as the different social reality experienced by the patient (Sainio-Rodriquez 2009:19-20). The underlying assumption in this final project was, that every individual is culturally unique and it is important to acknowledge that there is as much diversity within the cultural groups as there is between them (Giger & Davidhizar 2003:9).

2.3 Cultural competence

"Cultural competence in nursing refers to the ability to take into account people´s cultural beliefs, behaviors and needs in order to provide efficient health care. Cultural competence is merely a process rather than a specific skill." (Papadopoulos 2006:11.) Papadopoulos (2006:11) and Campinha-Bacote (2002:181) view cultural competence as an ongoing process and the latter emphasizes the requirement of health care providers to see themselves more like becoming culturally competent rather than already being culturally competent. To achieve this level, the health care professional must first and foremost be aware of one's own attitudes, beliefs and practices on cultural matters. One must be prepared and willing to adjust these attitudes and behaviour when encountering different views of the culturally diverse patients who do not share the same opinions and values (Vanderpool 2005:1925).

The most important tools for health care professionals in multicultural encounters are professional knowledge, understanding, sensitivity and interaction skills. Respecting both the patient and the patient's values are intertwined in the encounters. When discussing about different care options with the patients, the primary starting point is the respect for the patient's cultural beliefs, customs, life, values and following the patient's own will. Even though the decisions in health care are often made together with the family of the patient, it is still important to stress that the patient's own will and wishes will be heard. (Etene 2004:10.) As the amount of different cultures encountered is increasing in a speed, it is becoming more challenging for a nurse to obtain culture specific knowledge. (Sainola-Rodriquez 2009:52). This poses new challenges to the cultural competence education as well. It is important to begin teaching the cultural competency attitudes and skills already in the beginning of curricular studies; this

should include learning to assess diverse patients´ needs and increase understanding with their problems. Early introduction to cultural issues may help the future health care professionals to become more culturally competent and patient-focused as they start practicing their profession (Crosson, Deng, Brazeau, Boyd & Soto-Greene 2004:203).

It has been argued, that cultural competence is potentially arrogant, paternalistic and professional centered term. The term cultural competence may contradict with the ideas of patient-centered approach, where the decisions concerning health and well-being are done between the patient and the health care professional, the patient being an active participant in decision-making and not only a humble receiver of care. (Bischoff 2003:16). Transnational competence has been suggested to be a functional concept for describing the current phenomena and the needs in the multicultural health sector at the moment, although the concept has not yet been granted an official place in the nursing research (Sainola-Rodriquez 2009:29).

According to Sainola-Rodriquez (2006:129) transnational competence as a perspective does not necessarily exclude previous models of cultural competence, but may be utilized to complement these and add new perspectives to previous studies. In the cultural competence framework the role of a healthcare professional is perceived to be active and is expected to possess multifaceted knowledge about specific cultures, whereas transnational competence requires the nurse to see the patient as an active participant in the nursing process. The patient's own view of his/her own culture and its' meaning for the nursing process is seen as the primary issue in transnational nursing. (Sainola-Rodriquez 2009:52.) However, despite this criticism, the cultural competence model created by Campinha-Bacote (2002) was chosen to be used as the theoretical framework in this final project. The model was most widely used in the research articles, thus we decided to use it in order to remain consistent.

Within the discipline of transcultural nursing, several conceptual models have been created for describing the phenomenon of cultural competence. These models have their foundation in the transcultural nursing theories of Madeleine Leininger and are frequently utilized as a theoretical framework, when designing educational interventions to increase cultural competence of health care professionals and students. To

name a few of the models, Giger and Davidhizar (2003), Campinha-Bacote (2002), Papadopoulos, Tilki and Taylor (2006) have created their own models for cultural competence and transcultural nursing assessment. We chose to use Campinha-Bacote's model of cultural competence in health care delivery (2002) as the theoretical framework in this final project and it is defined next in more detail.

2.4 Campinha-Bacote's model of cultural competence in health care delivery

Campinha-Bacote´s model of culturally competent care presents cultural competence as a continuous journey like dynamic process, "in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client" (Campinha-Bacote 2002:181). Client in Campinha-Bacote´s model refers not only to individual patients, but also to families and communities (Campinha-Bacote 2002:181 & 2011:42-45). Cultural competence according to Campinha-Bacote (2011:45) has five constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. Cultural encounters are the foundation for development of the other four attributes. Cultural issues do not emerge solely from ethnicity or country of origin but also religion, language, gender, sexual orientation, age, disability, socio-economic status, physical size, political orientation, geographical location and occupational status bring up cultural questions; this makes all encounters cultural encounters. (Campinha-Bacote 2011:45.)

The five major constructs (cultural awareness, cultural knowledge, cultural skill, cultural desire and cultural encounters) of the cultural competence model by Campinha-Bacote (2002) are defined next in order to understand the model and its' utilization. We used the model for categorizing and interpreting the findings from the research articles included in the literature review, and this is explained in more detail in chapter 5.1.

Cultural awareness is the process of identifying one's own prejudices, assumptions and opinions on people who represent a different culture from one's own, by self-examination. This in-depth exploration should be done by reflecting with one's own cultural, personal and professional background and values. (Campinha-Bacote 2002:182.) According to Campinha-Bacote (2002:182) the second construct, cultural

knowledge, is the process of obtaining and actively seeking culture-specific knowledge on for example health and illness beliefs, traditions and religion on diverse cultural and ethnic groups. Cultural knowledge includes also obtaining information on bio physiological factors, for example disease incidence and ethnic pharmacology and epidemiology.

Cultural skill refers to the ability of making an adequate physical cultural assessment of the client's status and collecting and combining relevant information together in order to determine the need for care and plan the most appropriate interventions. (Campinha-Bacote 2002:182.) The cultural encounters consist of the direct interaction between the health care professional and a client from a different cultural background. These encounters further refine and modify the care givers pre-existing beliefs on the specific culture and possibly prevents stereotyping, however, Campinha-Bacote (2002:182) reminds that interacting with just a few representatives of a specific culture will not make the health care professional an expert on the cultural group. The last of the five constructs, cultural desire, refers to the motivation and thrive for actively pursuing towards cultural competence. The health care professional should have a genuine passion to be open and willing to understand and accept different worldviews, and to learn from the clients as cultural informants. (Campinha-Bacote 2002:184.)

2.5 Cultural competence assessment tools

Nursing researchers have developed several measurement tools for assessing the level of cultural competence of health care professionals and nursing students. These instruments are either qualitative or quantitative by nature, the latter being the most frequently used. All the measurement scales to date are based on self-reported perceptions and behaviors. (Gallagher 2011:29; Kumas-Tan, Beagan, Loppie, MacLeod & Frank 2007:548.) The quantitative instruments used for assessing cultural competence are usually based on Likert and Likert like scales. Likert and Likert like scales consist of different statements and typical response options include "strongly agree", "agree", "disagree" or "true" or "false". (Lo-Biondo-Wood & Haber 2010:276.) The qualitative methods used for the same purpose utilize for example interviews, open ended questionnaires and student essays (Lo-Biondo-Wood & Haber 2010).

Kumas-Tan et al. (2007) have identified 54 distinct instruments used to evaluate cultural competence in training of health care professionals and nursing students. Some of the instruments were developed and used for a specific research, some were applied widely in several studies. The selection of an appropriate tool depends on the intended use and the targeted group, for example Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals-Student Version (IAPCC-SV) is designed specifically to measure the cultural competence levels among students in health professions (Gallagher 2011:31). The IAPCC-SV is a sub-scale for Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R), which is aimed for professional health care providers. Both of the scales are designed by Campinha-Bacote and they have been frequently used in studies evaluating pre- and post-learning interventions (Campinha-Bacote 2002:184). Other commonly used cultural competence assessment tools include Cultural Self-Efficacy Scale (CSES), Cultural Competence Assessment Instrument (CCA) and Cultural Awareness Scale (CAS) (Kumas-Tan et al. 2007:552).

2.6 Educational Interventions

The concept of educational interventions discussed and used in our final project comprises various methods and activities used to promote cultural competence in health care professionals and nursing students. Some examples of such interventions are lectures, presentations, group activities, discussions, care planning and case studies, immersion experiences, service-learning and role-playing. (Gallagher 2011:18.)

3 Purpose of the literature review and research questions

The purpose of this literature review was to identify effective educational interventions designed to improve nurses' and nursing students' cultural competence and describe the outcome of these interventions. The knowledge gained from this literature review can be used to further develop and amplify the contents of cultural competence trainings and improve health care for ethnic minorities.

The research questions were:

1. What kind of educational interventions have improved health care providers and nursing students self-reported cultural knowledge and competence?

2. What are the outcomes of cultural competence education?

4 Systematic literature review and content analysis

4.1 Literature review

Our final project constituted of a literature review. The purpose of a literature review is to develop a strong knowledge base to support the conducted research or other clinical practice activities (LoBiondo-Wood & Haber 2010:59). LoBiondo-Wood and Haber (2010:59) describe literature review as a broad, comprehensive, in-depth and systematic organized critique of published as well as unpublished research reports and theoretical literature. According to Polit and Beck (2006:133) literature reviews have several functions; they can work as inspiration for new research ideas, help to define gaps in research or help in developing new practices and guidelines. Quantitative researchers often conduct a thorough literature review to gather baseline information about the researched topic; qualitative researchers on the other hand often refrain from making an in-depth literature review before doing their research to avoid interweaving of previous research on their research interpretations and findings (Polit & Beck 2006:133). We chose to conduct a literature review rather than a meta-analysis, due to the heterogeneity of the studies.

4.2 Database search

An electronic search was conducted in February 2012 by using Cumulative Index of Nursing and Allied Health Literature (CINAHL), Education Resources Information Center (ERIC) and MEDLINE database was accessed through OVID. We performed several preliminary searches with various keywords, such as "multicultural nursing" and "diversity education" as well as "transcultural nursing". The keywords were narrowed down

by choosing the ones that produced the most relevant titles and abstracts to our topic. The utilized keywords in the primary search were “cultural competence”, “training”, “intervention”, “cultural sensitivity” and “patient outcome”. We limited the search to articles published between 2000 and 2012, written in English language and with a linked full text, when this was applicable in the database used. In the preliminary phase, we also conducted searches for research papers written in the Finnish language, however we could not find anything relevant to our topic. The information on the database search can be found in Appendix 2.

After selecting the key words and limitations, both reviewers performed primary searches independently, went through the titles of the articles retrieved by the key words and selected the most relevant articles to the topic for further reviewing. The next step was to read through the abstracts, and a consensus between reviewers was required for an article to be included for a full review. In case the title or abstract did not provide sufficient information, the whole article was reviewed to decide whether it would be included or not.

The database search on CINAHL with the keywords ‘cultural competence’ AND ‘training’ with the limitations mentioned before, resulted in total of 115 hits, from which we chose six relevant articles. Another search with the key words ‘transcultural’ AND ‘intervention’ with the same limitations, resulted in total of 30 articles and two of them were chosen. The third search was conducted with the key words ‘immersion’ AND ‘cultural competence’ OR ‘study abroad’ resulted in 39 articles out of which three were chosen for the literature review.

The search conducted in MEDLINE database (accessed through OVID) resulted in 68 hits with the keywords ‘cultural competence’ AND ‘training’. From these articles retrieved, two were chosen to be used in our literature review.

The keywords utilized in the search with ERIC were ‘cultural competence’ AND ‘training’ AND ‘health care’. In total, 115 articles were retrieved and only two selected for further reviewing. However, neither of the two was relevant to our topic so the articles were discarded, resulting the number of articles chosen from ERIC in 0.

In addition to electronic database search, we extracted articles manually from nursing journals and from the bibliographies of reviewed research papers. The journals included in the manual search were Journal of Advanced Nursing, The Journal of Continuing Education in Nursing, Journal of Clinical Nursing, Journal of Nursing Education and Journal of Transcultural Nursing. The screened journals were published between 2010 and 2012. Relevant titles and abstracts were identified from the nursing journals by reading through the table of contents of each journal. Again the consensus between reviewers was required for an article to be included for a full review. In total five articles, three systematic reviews and one meta-analysis were retrieved from journals and bibliographies.

4.3 Eligibility criteria

We included research articles that were answering to our research questions, were published 2000-2012 and were written in English language. Other criteria included:

- pre-test-post-test design
- content of the education was retrievable from the research paper
- methods, data collection and analysis, sampling procedure, limitations and reliability and validity were described and properly evaluated in the research paper
- Interventions designed for nursing students and registered nurses were included as well as interventions designed for multidisciplinary teams of health care providers and students; when the team included registered nurses or nursing students.

4.4 Content analysis

Content analysis may be perceived as a loose theoretical framework, which can be attached to various analysis ensembles. Research data can be analyzed inductively or deductively. Inductive content analysis proceeds from empirical data towards a theoretically outlined ensemble, research data is reduced and grouped according to themes selected from the research data. (Tuomi & Sarajärvi 2002:110-115.) In deductive content analysis, data is synthesized and categorized according to a chosen theory or con-

ceptual system. The chosen theory guides the analysis. When the framework for the analysis is structured, contents corresponding solely to the selected theory are derived systematically from the data. (Latvala & Vanhanen-Nuutinen 2001:23-24, 30-33; Tuomi & Sarajärvi 2002:97-99, 116.)

In this final project, the content analysis was designed according to a modified version of Elo´s and Kyngäs´s inductive content analysis process. In inductive content analysis the categories are derived from the data, in contrast to deductive content analysis, in which the categories are formulated according to previous knowledge (Elo & Kyngäs 2007:109). "Content analysis is a research technique for making replicable and valid inferences from texts … to the contexts of their use" (Krippendorff 2004:18). This basically means that researchers working under different circumstances in different times should be able to reach the same results when applying the same content analysis technique to the same data.

Contents of the 18 research articles that were retrieved for the literature review are summarized in Appendix 1. In the Appendix, the contents of the research articles are divided into different categories in order to aid the analyzing and conceptualizing of the articles. Categories include author, year and journal, purpose of the research, sampling procedure, duration and content of the education, method, data collection and analysis, main results, remarks, theoretical model guiding the intervention and intervention assessment tool.

In addition to inductive content analysis, we chose to use deductive content analysis to categorize the outcomes of the educational interventions presented in the studies. Campinha-Bacote´s cultural competence model, consisting of cultural knowledge, cultural awareness, cultural skill, cultural desire and cultural encounters (Campinha-Bacote 2002), was chosen because of its' clarity. These five constructs of cultural competence appeared in many of the studies and even if some other categorization method was used, these constructs appeared functional.

5 Findings

The purpose of this final project was to analyze and describe the outcome of educational interventions designed to improve the cultural competence of nurses and nursing students. A total of 22 studies met the criteria for inclusion in the literature review. 18 of the included studies were a pre-post research design, three literature reviews (Beach et al. 2005; Chipps, Simpson & Brysiewicz 2008; Lie, Lee-Rey, Gomez, Bereknyei & Braddock 2011) and one meta-analysis (Gallagher 2011). One of the studies was a randomized controlled trial (Berlin, Nilsson & Törnkvist 2010). The participants in the educational interventions in all of the research studies were either health care professionals or baccalaureate/college students from the fields of nursing and medicine. In addition to nursing and medical students, a study by Musolino et al. (2009) also included other healthcare students in their sample (physical/occupational therapists and pharmacists).

In nine of the studies, the educational intervention was allocated for healthcare students (Amerson 2010; Caffrey, Neander, Markl & Stewart 2004; Campbell-Heider et al. 2006; Carpenter & Garcia 2012; Hunter & Krantz 2010; Larsen & Reif 2011; Musolino et al. 2008; Nokes, Nickitas, Keida & Neville 2005; Walton 2011). The interventions for students were either culture related courses integrated into the curricular studies, international immersion experiences or service-learning interventions. Service-learning is a form of experiential education in which the students have the opportunity to connect theory with practice by working inside a community, emphasizing the experiential learning, community engagement and community self-reflection (Katz 2009:20). The other 9 studies were aimed for health care professionals (Berlin et al. 2010; Cooper-Brathwaite & Majumbar 2006; Lee, Anderson & Hill 2006; McGuire, Carćes-Palacio & Scarinci 2012; Moffat & Tung 2004; Papadopoulos, Tilki & Lees 2004; Salman et al. 2007; Schim, Doorenbos & Borse 2006; Taylor-Ritzler et al. 2008) and the trainings were mainly interactive lectures. There was only one study aimed for healthcare professionals that combined both lectures and clinical work experience (Berlin et al. 2010).

Different tools and educational methods were used in the interventions. Generally the cultural competence trainings utilized a combination of both experiential and non-experiential formats in the research studies, for example lectures, role-playing, group activities, didactic discussions, online-courses, DVD's and videos, workshops and case

studies. The duration of the interventions differed in the studies, varying from one semester- long cultural competency courses integrated in academic curricula to one-day single session interventions, as short as one hour. Also the contact time varied, for example in the study by Walton (2011) the intervention was a single presentation for 60 minutes, whereas in Taylor-Ritzler et al. (2008) the intervention contact time was 7 hours, a full day.

5.1 Effective training methods

Almost all educational interventions used in the research studies had positive effects on at least some facets of cultural competence levels of the participating healthcare professionals and students. There were three studies that either did not find any statistically significant improvements in the cultural competence levels, or confoundedly the cultural competence levels deteriorated (Musolino et al. 2008; Nokes et al. 2005; Papadopoulos, Tilki & Lees 2004). We could not identify any particular educational intervention that would have been more effective than the other, thus all the educational interventions are next discussed in more detail and they are compartmentalized into two categories, based on whether the intervention was founded on experiential or non-experiential learning methods.

5.1.1 Cultural immersion, service-learning and other experiential learning methods

The research studies that had an international or national cultural immersion as their intervention were merely for healthcare students. In total four studies conducted an international immersion either in Guatemala, South Africa or in Mexico (Amerson, 2010; Caffrey et al. 2004; Carpenter & Garcia 2012; Larsen & Reif 2011) and in one study the immersion was performed inside a local community with a diverse patient population (Campbell-Heider et al. 2006). The international immersion experiences included for example living with a local family, working at the clinics directly with the nurses and physicians and giving patient education. The duration of the international immersion interventions varied from one week to six weeks and three of the four studies had used a two-group comparison study design. The results in all of the three studies indicated that the interventions groups gained more cultural competence than the control groups who did not take part in the immersions. Carpenter and Garcia

(2012) assessed the outcomes of a compulsory Spanish language course for baccalaureate nurses, which they transformed from a traditional classroom course into a 6-week cultural immersion experience in Mexico. No control group was used, and the quantitative findings showed no drastic changes in the students' beliefs and attitudes. However the qualitative methods used (interviews, written answers for open-ended questions, journals) demonstrated an improvement in cultural knowledge and awareness. Overall all the results of the immersion interventions proofed it to be an effective method in educating on cultural matters.

Two studies utilized the service-learning technique, which has been described as the experiential learning experiences that combine service and learning. It includes community service with distinct learning objectives with an emphasis on reflection about the service work and its relationship to professional education. (Neville 2003.) The control group in the study by Amerson (2010) co-operated in service-learning projects with local communities, whereas the intervention group collaborated with international community projects in Guatemala. The improvement in cultural competence among both groups was evident, more so with the intervention group. The service learning approach was also utilized in Nokes et al. (2005) but was not clearly defined in the research study. The results were somewhat confounding in that the post-intervention evaluation scores were lower compared to pre-evaluation (Nokes et al. 2005:68). On the strength of the inconsistent results from these two studies, we could not determine whether the service-learning is an effective method to enhance cultural competence or not.

5.1.2 Class room, online and other non-experiential learning methods

The non-experiential learning methods in the interventions included traditional theory-based lectures for students and healthcare professionals, online-courses, on-site workshop sessions and merely didactic instructor-led presentations. Most of the research studies did combine both experiential and non-experiential learning and teaching methods in the interventions, for example group discussions and other group activities, case studies and role playing. (Berlin et al. 2010; Campbell-Heider et al. 2006; Lee et al. 2006; McGuire et al. 2012 Taylor-Ritzler et al. 2008; Walton 2012.) Very few studies based their educational interventions merely on the more passive, non-experiential

methods. McGuire et al. (2012) executed the educational intervention through live presentations and DVDs on Latino patients' cultural beliefs, where the participating nurses were more in a passive recipient role. The results were showing that the intervention had increased the participants' cultural knowledge (McGuire et al. 2012:80). Some of the studies did combine both the active and the passive learning methods in the educational interventions, but the overall atmosphere was primarily passive (Caffrey et al. 2004; Hunter & Krantz 2010; Lee et al. 2006; McGuire et al. 2012; Moffat & Tung; 2004; Musolino et al. 2008; Walton 2011).

5.2 Outcomes of the cultural competence interventions

We decided to divide the outcomes of the studies into five categories according to a model of cultural competence in health care delivery by Campinha-Bacote (2002). The components of the model are as follows: cultural knowledge, cultural awareness, cultural skill, cultural encounters and cultural desire. The model was frequently used as the theoretical background of the conducted interventions in the studies, or the IAPCC assessment tool developed by Campinha-Bacote was used to assess the effect the interventions had on cultural competence of the participants. The research studies that categorized their results on different foundations, however had aspects of some of these five constructs and did fit into the classification method we chose.

5.2.1 Improved cultural knowledge

Increase in cultural knowledge was the most commonly reported outcome in the studies included in our final project. Beach et al. (2005:5) and Chipps et al. (2008:90) had also acknowledged the same finding in their literature reviews. A total of 14 out of the 18 studies had specified a statistically significant improvement in knowledge or cognitive aspects on cultural matters. Half of the overall interventions provided culture-specific education, including teaching on the health related beliefs, attitudes and practices of for example Latin-Americans (Amerson 2010; Caffrey et al. 2005; Carpenter & Garcia 2012; McGuire et al. 2012), Native Americans (Walton 2011) and Hispanic population (Lee et al. 2006). These studies reported the improvement in cultural knowledge more frequently than the ones with no specific ethnic content in their interventions. A study by Schim et al. (2006) did not specify the ethnic culture on which

they gave education on, but referred to including some information on the minorities served on that specific area the participating hospice workers were working in. The main focus of Salman et al. (2007) workshops was on ethnogeriatrics, introducing the basic elements of culturally competent care of the elders from different ethnic backgrounds.

Campbell-Heider et al. (2006) gained proof of the positive effect of culture-specific education on the cultural knowledge on students. They however questioned the connection between cultural knowledge and being culturally competent, since "Theoretically one could have much knowledge of other cultures and still be ethnocentric and hostile while one could be open-minded and tolerant but ignorant" (Campbell-Heider et al. 2006:27). Therefore they presented the need for using multiple cultural competence measures to attain accurate results.

5.2.2 Improved cultural awareness

Cultural awareness was often integrated within the overall concept of cultural competence in the studies and, therefore, it was analyzed as such less frequently than cultural knowledge. In some studies the concept of cultural awareness was used interchangeably with the concept of attitude. A few studies, however, specified the outcome of the interventions regarding cultural awareness. Campbell-Heider et al. (2006) and Carpenter and Garcia (2012) had acknowledged the improvement in cultural awareness in their qualitative interviews and open-ended questionnaires, where the participants reported that they regard people as individuals and express more open-mindedness, that is, being culturally aware (Campbell-Heider et al. 2006:29; Carpenter & Garcia 2012:88). Musolino et al. (2008) concluded that majority of the participants achieved the level of cultural awareness, but had not yet reached the level of cultural competence. Berlin et al. (2010) and Hunter and Krantz (2010) did not find any statistical change or improvement in the level of cultural awareness and in a study by Papadopoulos et al. (2004) two participating nurses surprisingly deteriorated on their level of cultural awareness. The researchers postulated that the deterioration was due to the fact that the post-assessment questionnaire was administered right after the intervention and suggest that it could be more useful to re-assess the impact of the educational intervention several months after the implementation, since this kind of trainings

have longer-term effects. (Papadopoulos et al. 2004:113.) However, in majority of the studies the overall effect of the educational interventions had a positive influence on the cultural awareness and total cultural competence.

5.2.3 Cultural skill, Cultural encounters, Cultural desire

The last three components of cultural competence, cultural skill, encounters and desire, were not defined and analyzed as often as the concepts of cultural awareness and knowledge in the studies. An improvement in cultural encounters was shown particularly in the national or international immersion programs, in which the participants (mostly baccalaureate nursing or other healthcare students) either spent one to six weeks abroad or in a health care provider shortage area. Caffrey et al. (2004) utilized a two group comparison design, where the intervention group had a 5-week clinical immersion experience in Guatemala and the control group had cultural content integrated in the curricular studies. The results were clearly showing that the improvement in cultural competence was significantly greater for students in the intervention group than for the ones in control group, although they had also improved moderately. Similar results were also found by Larsen and Reif (2011:352) and Amerson (2010:21). Majority of the studies performing an international immersion intervention showed increased levels of cultural competence and cultural desire. One of the limitations mentioned in these studies was however, the fact that the participants for the immersion interventions were volunteers, which might indicate that they initially had a vested interest for becoming culturally competent. (Amerson 2010; Caffrey et al. 2004; Larsen & Reif 2011.)

The improvement in cultural desire was recognized by few studies. Musolino et al. (2008:60) had integrated culture-related content in the curricular studies, but did not find any significant improvement neither in cultural encounters nor in cultural desire. On the contrary, a study in which the educational intervention combined both theoretical lectures and clinical work, 92% of the 51 nurses increased their cultural desire in response to educational intervention (Berlin et al. 2010:386).

6 Discussion

The purpose of this literature review was to identify effective educational interventions designed to improve nurses’ and nursing students’ cultural competence as well as to describe the outcome of these interventions. The research questions were: what kinds of educational interventions have improved health care providers and nursing students self-reported cultural knowledge and competence? And what are the outcomes of cultural competence education?

Findings from our literature review were in line with the findings of literature reviews conducted on the same topic by Beach et al. (2005), Gallagher (2006) and Chipps et al. (2008). All of these reviews indicated a statistically significant increase in cultural competence after various kinds of cultural competence trainings. A total of 14 out of the 18 research studies specified a statistically significant improvement in knowledge or cognitive aspects on cultural matters after cultural competence training. 15 studies reported a statistically significant post-training improvement in the overall cultural competence.

Half of the interventions provided culture-specific education, including teaching on the health related beliefs, attitudes and practices of for example Latin-Americans (Amerson 2010; Caffrey et al. 2005; Carpenter & Garcia 2012; McGuire et al. 2012), Native Americans (Walton 2011) and Hispanic population (Lee et al. 2006). These studies reported the improvement in cultural knowledge more frequently than the ones with no specific ethnic content in their interventions. The contents of these educations are culture specific and thus, not applicable in all cultural competence training. Furthermore, the whole concept of teaching culture specific knowledge can be criticized for its’ potential ethnocentricity and stereotyping approaches.

Service learning and cultural immersion show promise as strategies to improve nursing students’ cultural competence but there is a need for future studies with some methodological improvements. Studies that were comparing the outcome of cultural immersion intervention and traditional class room teaching had some methodological limitations. In two studies (Carpenter & Garcia 2012; Larsen & Reif 2011) the effects of the cultural immersion interventions on the cultural competence of nursing students was evaluated, participation to the intervention group was voluntary and students had to

apply for the intervention group, causing possible sampling bias. Students had applied for the exchange, which means that they had personal interest on developing their cultural competence. Control groups were formed of students, who did not qualify for the intervention group. This division may have caused that the students in the control group were less culturally competent at the initial level. Another limitation for the applicability of the findings is that the contents of the interventions were not extensively described in most studies, which makes it difficult to give specific suggestions for practice. This may be due to the fact that many journal publications may limit the length of the published descriptions. (Price et al. 2005:583).

In a study conducted by Musolino et al. (2008) students from the faculties of physical therapy, occupational therapy, pharmacy, medicine and nursing were assessed on the effects of the cultural-competence training. The limitation in the study was that the comparison groups consisted solely of medical and pharmacy students. According to Price et al. (2005:583) comparison groups should be similar to the group receiving the intervention; otherwise the effect of the training cannot be separated from the possible influence of other environmental factors (Price et al. 2005:583). Most studies used convenience sampling, where participants were allocated to intervention and comparison groups based on different study groups or workplaces (Hunter et al. 2010; Amerson 2010). Randomization would minimize the possible selection bias; however we were able to find only one study which used randomization (Berlin et al. 2010).

We found out that there is a lack of studies that would measure the impact of cultural competence training on the patient outcome, parallel with the suggestion by Beach et al. (2005). We would like to emphasize the need for future studies that would examine whether cultural competence training has an actual effect on the patient outcome and whether the education really reduces racial and ethnic disparities in health care services. Walton (2011:22) suggests that traditional cultural training for healthcare professionals is often limited in reducing health disparities as it might not help the health care professionals meet the needs of individual patients. Cultural training may fail to emphasize the multiplicity of worldviews of the healthcare professionals themselves as well as the worldviews of the patients (Walton 2011:22). There is also a possibility that cultural competence training would actually result in ethnocentrism, stereotyping and othering. Othering as a concept means distancing oneself from those one perceives as

different and can occur both consciously and unconsciously. (Dharamsi 2011:764; Canales 2000:18.). The threat in othering is that it may inflict discriminatory treatment of patients and lead to reinforcement of health care professionals' authority and subjection of the patients' (Johnson et al. 2004:253).

The studies included in this literature review were conducted in diverse health care facilities and in different parts of the world. Most of the studies (15) were conducted in the United States, one in Canada, one in Sweden and one in United Kingdom. The requirement for cultural competence in health care is universal, although there are variations in the focus areas and in the way health care services are organized in different parts of the worlds. Racial and ethnic disparities in health are relatively new and growing issue in Europe and Scandinavia, whereas in the United States the disparities have been reality for a longer period of time.

Despite the fact that majority of the studies were conducted in the United States, we believe that the findings of this literature review are useful in the context of Finnish health care system as well. This literature review supports the positive outcomes of cultural competence trainings given for nurses and nursing students. Based on the findings of this literature review, we recommend that cultural competence training should be included in the curricular studies of all nursing schools in Finland and it should also be offered as continuous education for registered nurses. However, based on this final project, it is not possible to give specific recommendations for practical applications about the most effective educational interventions due to the heterogeneity of the health care contexts in the studies and study limitations. We hope, however, that this literature review will assist health care professionals and lecturers in developing the contents and choosing the methods for conducting cultural competence training in their specific area. We also hope that this literature review aids the reader to critically view the current cultural competence education.

7 Limitations and ethical considerations

7.1 Validity

"Validity is the extent to which an instrument measures the attributes of a concept accurately" (LoBiondo-Wood & Haber 2010:286). Basically this means the determination of how well the literature review reflects the concept that has been examined and how valid the results and findings are (Burns & Grove 2011:334).

This was the first systematic literature review we have ever conducted. The lack of experience in doing systematic literature reviews is a possible threat to the reliability of the findings of this final project. We tried to minimize the bias caused by lack of experience in conducting systematic literature reviews by carefully reading guidelines on how to do a systematic literature review. For this literature review we only included scientific articles from reliable and professional databases. We also designed and used strict eligibility criteria for the articles to be included.

7.2 Limitations

There are some limitations in this literature review. We were not able to access all relevant articles as we did not have the resources to purchase articles that were subjects to charge. Due to the exiguous amount of studies relevant to our topic, studies with quasi-experimental study design with one-group pre-test-post-test designs (Moffat & Tung 2004, Lee et al. 2006 Campbell-Heider et al. 2006 and McGuire et al. 2012, Cooper- Brathwaite & Majumdar 2005, Nokes et al. 2005 and Papadopoulos et al. 2004) were included, as these were answering our research questions. Evidence gained from this literature review would be stronger, if all the reviewed studies would have been randomized controlled trials (RCTs).

There is possible selection bias, caused by the choice of keywords that were utilized in the database search for the literature review. Several synonyms and synonym like terms were used to describe the phenomenon of cultural competence. In the preliminary searches we used various search terms, but later on decided to narrow the keywords down for the primary search. Most studies included in this literature review used Campinha-Bacote's model of cultural competence as a theoretical framework. This

prominence of one cultural-competence theory in the studies might be caused by the selection of search terms.

7.3 Ethical considerations

According to Burns and Grove (2011:137), the goal of research is to establish in-depth scientific knowledge without any research misconduct and also acknowledging the ethical aspects of studies. We have taken into account the ethical considerations in this final project by avoiding research misconduct that includes fabrication, falsification and plagiarism (Burns & Grove 2011:137). We reported the findings from the research articles accurately, without manipulation or fabrication, which is the making up or falsifying the research results. All the authors were correctly cited in the text and we made sure that the original sources where identified for quotations. We did not include our own ideas or interpretations in the analysis of the studies. The studies included in the review all followed good research ethics.

8 Conclusion

The overall findings from our literature review indicated that educational interventions do increase the cultural competence levels of nurses' and nursing students'. 15 out of the 18 research articles did find significant improvements in the cultural competence scores and levels of professional nurses and nursing students after the educational intervention, and only three studies did not identify any remarkable changes. Furthermore, regardless of the intervention type, learning methods used and targeted recipients; the educational interventions seemed to have and an equal, positive effect on cultural competence levels. The limitations mentioned before should be taken into consideration when interpreting and utilizing the results from this literature review. Further research is still needed to gain evidence on the relation between actual practice and theory of cultural competence; how does the culturally competent nursing care provided by the health care professional manifest itself for the patient or the client and is it as adequate and sufficient as the self-reported findings suggest.

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Article Analysis

AUTHOR(S), YEAR, JOURNAL	PURPOSE	PARTICIPANTS (SAMPLE SIZE)	DURATION AND CONTENT OF EDUCATION	METHOD,DATA COLLECTION AND ANALYSIS	MAIN RESULTS	REMARKS	THEORETICAL MODEL	ASSESSMENT TOOL
Amerson, R. (2010) The Impact of Service-Learning on Cultural Competence. *Nursing Education Perspectives. 3*1(1). 18-22.	To evaluate the self-perceived cultural competence of baccalaureate nursing students enrolled in a community health nursing course following the completion of service-learning projects with local and international communities.	69 baccalaureate nursing students in seven groups of six to 11 students. One group of six students participated in a one-week international immersion experience in Guatemala.	Students developed a culturally appropriate care plan, interviewed key informants to gain knowledge on the community's view of health issues. In addition, the immersion group in Guatemala worked with a multidisciplinary team as a part of a medical mission in rural villages.	Multiple groups, pre-test post test-design, Multivariate analysis, paired-samples t-test using SPSS software	Increase in the abilities in cognitive, practical, and affective dimensions following participation in a service-learning project. The international group scored lowest on the pretest, yet scored highest in all areas on the posttest.	Limited sample size, only 6 or 11 in a group.	Giger and Davidhizar Cultural Assessment Model (2004)	Transcultural Self-Efficacy Tool (TSET), based on Giger and Davidhizar Cultural Assessment Model (2004)

AUTHOR(S), YEAR, JOURNAL	PURPOSE	PARTICIPANTS (SAMPLE SIZE)	DURATION AND CONTENT OF EDUCA-TION	METH-OD,DATA COLLEC-TION AND ANALYSIS	MAIN RE-SULTS	REMARKS	THEO-RETICAL MODEL	ASSESSMENT TOOL
Berlin, A., Nils-son, G., Törn-kvist, L. (2010): Cultural compe-tence among Swedish child health nurses after specific training: A ran-domized trial Sweden. *Nursing and Health Sci-ences* (2010), 12, 381–391	To evaluate the extent to which specific training affects how nurses rate their own cultural competence, difficulties, and concerns and to study how nurses evaluate the training.	51 nurses were selected randomly from 15 randomly chosen municipalities in Sweden. The municipalities chosen to the research had at least 20% of children with immi-grant parents; 24 nurses in inter-vention group(IG) and 27 in the control group(CG)	3 days, 3rd day after 4 weeks of clinical work. This study had a clearly and precisely de-scription of the contents of the education. The education included discussing previous research using Campinha-Bacote's cultural-competence model as a frame-work. -Participatory learn-ing -Linking theory to practice -cases -reflective groups Intended learning outcomes were defined in the re-search article	Randomized Controlled trial. The analysis compared pre- and post-training out-comes within and between IG and CG nurses.	Training had some effects on the cultural compe-tence and diffi-culties and con-cerns among the nurs-es who received the training when compared to those who did not .	Gained knowledge of a topic scarcely studied in nursing science; results may be utilised in de-veloping patients' and their spouses guidance and support at hospital. IG had higher degree of linguistic ability and previous training in cultural-competence CG had more missing an-swers-possible bias, small sample size, short term follow up Research followed the recom-mendations by Price et al. (2005) Knowledge of the nurse's and parents difficulties and concerns with interactions used when creating the training program-> positive evaluation concerning the train-ing's quality	Campinha-Bacote	The Clinical Cultural Competence Training Questionnaire-pre (CCCTQ-PRE) and the Clinical Cultural Competency Training Evaluation Questionnaire-post (CCCTEQ-POST) were used.

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Caffrey, R. A. Neander, W. Markle, D. Stewart, B. (2004) Improving the Cultural Competence of Nursing Students: Results of Integrating Cultural Content in the Curriculum and an International Immersion Experience. *Journal of Nursing Education.* 44(5). 234-240.	To evaluate the effect of integrating cultural content (ICC) in an undergraduate nursing curriculum on students' self-perceived cultural competence. To determine the effects of 5-week clinical immersion in international nursing (ICC Plus) on students' cultural competence.	32 female nursing students of which: 7 had 5-week immersion on their senior year (ICC Plus) and the other 25 continued with traditional senior-year clinical assignments (ICC)	ICC group: Cultural concepts were incorporated into course materials. Also multicultural case studies were used. Immersion (ICC Plus) group: 5-weeks (200-hours) in general medical clinics in Guatemala	Two-group, pretest-posttest, quasi-experimental design.	ICC group: Moderate improvement in culturally competent attitudes, knowledge, and skills over the 2 years in the nursing program. ICC Plus immersion group: Graded themselves significantly more culturally competent than the ones completing normal senior year.	Limitations were: Whether self-perceived cultural competence has any relationship to actual practice. Small sample size.	-	The Caffrey Cultural Competence in Healthcare Scale (CCCHS); 28-item self-rating on a Likert scale

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Campbell-Heider, N. Pohlman Rejman, K. Austin-Ketch, T. Sackett, K. Feeley, T. Wilk, N.C. (2006) Measuring Cultural Competence In A Family Nurse Practitioner Curriculum. The Journal Of Multicultural Nursing & Health. 12(3). 24-34.	To describe the development, implementation and evaluation of a new family nurse practitioner curriculum (FNFC) designed specifically to educate students to be clinically and culturally competent.	14 students started program, 12 completed.	Three courses that integrate clinical topics, clinical practice, and advanced practice theory. First two focus on increasing student self-awareness of their own ethnocentrism and on the nature of stereotypes. Third course focuses on acquiring multicultural knowledge and skills.	One group , Multiple formative and summative clinical, survey, and qualitative measures. Cultural skills and attitudes were tested before, during and post completion of the program.	Increase in cultural knowledge as measured on Culture Quiz. No change in tolerance or openness to persons from other cultures No changes in students' value orientation towards viewing the world as a singular or whole system rather than an amalgam of separate regional or national parts.	-	Benner's (1999) "novice" to "expert model" to conceptually organize clinical and cultural content and skills.	Culture Quiz (CQ) 25 true/false cultural knowledge items. Xenophilia scale (XS), 35-item scale measuring students' tolerance or openness to persons from other cultures. Cross-Cultural World-Mindedness (CCWM) measures one's value orientation (using 26 items) toward viewing the world as a singular or whole system rather than an amalgam of separate regional or national parts

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Carpenter, L. and Garcia, A. (2012) Assessing Outcomes o f a Study Abroad Course for NURSING STUDENTS. *Nursing Education Perspectives.* 33(2), 85-89.	To explore how studying abroad influenced on students' awareness, sensitivity, knowledge, and skills related to culture	35 college nursing students	Living with a Mexican family, studying at language school and collaborating on projects with public health nurses and nursing students from the University of Guadalajara., Mexico.	Quantitative (survey) and qualitative (interviews, journals, and written responses to open-ended questions) methods	Classroom experiences not effective in helping students become more comfortable interacting with people from different cultures. Experiential teaching strategies, (field trips, post conferences, reflective journaling) more effective. Study abroad: deeply personal learning opportunity resulting in enhanced awareness, sensitivity, knowledge, and skills important for addressing cultural differences in nursing practice.	-	The National League for Nursing toolkit on innovations in curriculum design (2011) (by American Academy of Colleges of Nurses) was used for choosing learning strategies.	Modified version of Cultural Awareness Survey (CAS)

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Cooper-Brathwaite, A., Majumdar B. (2006): Evaluation of cultural competence educational program. Journal of Advanced Nursing 53(4), 470-479	To evaluate the effectiveness of a cultural competence educational program in increasing Public Health Nurses' cultural knowledge	76 Public Health Nurses (75 females and 1 male) working in Public Health Department in Southern Ontario Canada.	Five 2-hour sessions over 5 weeks and a booster session after 1 month. Introduction of transcultural terms+ Campinha-Bacote's model of cultural-competence, awareness of own culture+ other cultures, knowledge on biological varitions+nutritional preferences, cultural assessments, cross-cultural communication. Intervention combined experimental and non-experimental learning, reflection, discussion, role-play, games. In booster session to discuss nursing experiences and ability to apply concepts of cultural-competence in practice	Combination of quantitative and qualitative methods. Qualitative data were content analyzed. Quantitative data was collected at 4 points in time; T1 baseline, T2 pre-test, T3 immediate post-test and T4 3-month follow-up	Findings revealed that the intervention was effective in increasing nurses` cultural knowledge.	The findings are not generalizable to nurses in other settings, however the program could be adapted to nurses in other settings. Influence of maturation, 100$ random prize for participants	Campinha-Bacote	Cultural knowledge was measured on the Cultural Knowledge Scale (CKS)(5-point Likert scale with 24 items), data was collected at 4 points in time.

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Hunter J.L., Krantz S. (2010) Constructivism in Cultural Competence Education. Journal Of Nursing Education 49(4) 207-213)	To find out if: - The educational experience build on constructivist learning theory tenets changes student's perceptions, attitudes, knowledge and skills in the area of cultural competence. -Does the delivery method influence the degree of change; online vs. class-room?	Graduate-level nursing students 48 (of 52) assessment pairs in class-room were completed and 21 (of 24) in online course.	One semester. The course was given in four units each one based on one of the modules is Campinha-Bacote's model. Each unit consisted of an introduction, related readings, assignment and discussion. Assignments were experiential and cognitive.	Quasi-experimental pre-test- post-test control-group design.	Findings indicate that both the online and class-room courses were equally effective. Students' cultural knowledge, cultural skill, cultural desire and overall cultural competence were tested higher after completing the course. In cultural awareness and cultural encounters the change was not significant.	There is need for further development and testing of measures of cultural competence.	Campinha-Bacote	IAPCC-R(Campinha-Bacote, 2003) consists of 25-items measuring five constructs of cultural competence as well as quantifying total cultural competence

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Larsen, R. and Reif, L.A. (2011) Effectiveness of Cultural Immersion and Culture Classes for Enhancing Nursing Students' Transcultural Self-Efficacy. Journal Of Nursing Education. 50(6), 350-354.	To determine the effect of short-term immersion vs. culture classes on nursing students' transcultural self-efficacy Is there a correlation between the number of culture classes taken and the pre-test and post-tests scores	N=14 nursing students who completed an immersion experience, n=25 nursing students who did not complete an immersion experience, both the IG and CG had applied for the cultural immersion program, all students reported white.	1 and 2cr cultural courses that addressed culture and health care, including topics such as African American health, Native American Health and border culture. Cultural immersion was a 2-3 weeks long course, one in South Africa, one in Juarez	A two group, pre-test-post-test, quasi-experimental design, SPSS was used for data-analysis	Cultural immersion increased students' transcultural self-efficacy significantly more than culture classes. There was no correlation between the numbers of cultural courses taken.	Limited sample size.	Transcultural self-efficacy Jeffreys (2006) etc.	Transcultural self-efficacy tool designed by Jeffreys(2006)

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Lee C., Ander-son M., Hill P. (2006) Cultural sensitivity education for nurses: A pilot study. The Journal of continuing education in Nursing 37(3) 137-141	Explore the effect of an educational intervention about selected Hispanic health beliefs and prac-tices on the nurses who provide care for this population.	Convenience sample of 7 registered nurs-es, all white females from small rural Midwestern health department.	90-minute education pro-gram	Experimental one group pre-test-post-test design. 12-item demographic survey and pre-test prior to the intervention and identical post-test immediately after the intervention. Data was analyzed using SPSS.	Findings showed that the interven-tion increased knowledge of selected Hispanic health beliefs and practices.	Small sample limits the re-sults of this study, pilot study	Leininger (1985,1988)	Lee Cultural Sensitivity Too: Hispanic version. 10 items

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McGuire A., Carćes-Palacio I. C., Scarinci I. C. (2012) A Successful Guide in Understanding Latino Immigrant Patients-An aid for health care professionals. Family community Health 35(1) 76-84.	The article describes the development, implementation and evaluation of a short educational DVD titled, A guide to working with Latino patients in Alabama, developed to aid professionals in providing culturally competent care to Latino Immigrants.	Of the individuals who participated in the training 513 completed the baseline assessment and 458 completed the post-training assessment. Training was offered online, on-site, through a national Web cast, and via hard copies of a DVD mailed upon request	Data collection took place between fall of 2007 and April of 2010. Training was offered online, on-site, through Web cast, DVDs. On-site: conferences, community meetings, mainly presentations and recorded portions of the DVDs.	Pre- and post-test assessments were conducted with each mode of delivery to evaluate the changes in knowledge. Statistical analyses were conducted using SPSS.	Most of the questions had a high percentage (80%) of correct answers at baseline, but there was significant increase in the post-training test in cultural knowledge. At the end of the training participants perceived themselves more knowledgeable about Latino Cultural Beliefs associated with health care seeking and health in general, as well as barriers to health care for Latinos than before the training.	Offering trainings through multiple media methods may be successful in educating health care professionals on the Latino immigrant population. Participation was voluntary, so the participants may be based on the individuals interest in Latino immigrant health topic. The study relies on self-reported data and self-perceived increase in knowledge.	-	The measurements consisted of demographic data and 12 multiple choice questions at baseline and following the training session.

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Moffat J., Tung J-Y. (2004) Evaluating the effectiveness of culture brokering training to enhance cultural competence of independent living center staff Journal Of Vocational Rehabilitation 20, 56-59	To exam and analyze the effectiveness of Culture Brokering training on outreach to culturally diverse communities.	Independent living centre staff was recruited from three culture brokering workshops held in California during July 2002. Sample size n=50. Only those participants who completed both days of the workshop participated tin the study.	Two Days. Worshops; lecture, video vignettes, case studies, group activities and discussions.	A one-group pre-test-post-test quasi-experimental design. Pre-test included a competence-test and a knowledge test. Participants completed a knowledge test immediately after the workshop. Post competence-test was returned within 2 months after completing the workshop.	Forty-one out of 49 participants (84%) increased their knowledge scores after the workshop. Workshop participants increased their cultural competence scores on 35 items of the 36 items (97%); 25(69%) items were increased with statistical significance. Twenty-nine out of 41 participants (71%) increased their total scores after the workshop.	More research is needed to evaluate the effectiveness of cultural brokering training on consumer satisfaction and community outreach to minority populations.	-	The Culture Brokering Pre Post Questionnaire.

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Musolino, G. Babitz, M. Burkhalter, S. Thompson, C. Harris, R. Ward, R.S. Chase-Cantarini, S. (2008) Mutual Respect in Healthcare: Assessing Cultural Competence for the University of Utah Interdisciplinary Health Sciences. Journal of Allied Health. (38)2. 55-62.	To assess the Cultural-Competence and mutual respect pre/post learning outcomes	n=100 medical students, n=140 nursing students, n=36 physical therapy students, n=11 occupational therapy students and n=53 pharmacist students, control data was collected from n=100 medical students and n=36 physiotherapist students	Fall -03 and spring -04 4 modules, two hours each. Reflection on: individual perspectives and differences, disparate health care, own culture, beliefs and attitudes. Own approach to cultural encounters comparing systems related to culture, skills learning, interdisciplinary staff member sharing their experiences Colleges/Schools. Reference materials related to specific cultural groups were provided in web-based, resource format only.	Pre-test post-test control group design	All students increased in overall scores in cultural awareness, approaching competence, but not yet reaching cultural-competence	Students with an non-white ethnic background, had higher mean scores Comparison of the results of the nursing students should be interpreted with caution, because the CG constituted of medical and physiotherapy students Nursing students had higher scores in the mid -point and lower at the post-test	-	IAPCC-R

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Nokes, K. Nickitas, D. Keida, R. Neville, S. (2005) Does Service-Learning Increase Cultural Competency, Critical Thinking , and Civic Engagement? *Journal of Nursing Education.* 44(2) 65-69.	To develop a 15-hour service-learning intervention; refine the 15-hour service-learning intervention; and explore whether participation in the intervention made a difference in the critical thinking, cultural competence, and civic engagement of nursing student participants.	14 students	15h in person and 7h online. Service-learning. Content not clearly defined, did however include group discussions and lecture.	One group pre-post-test.	Cultural competence levels deteriorated intervention not very successful.	No control group. Measures also critical thinking and civic engagement of participants.	-	CCTCI and IAPCC-R

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Schim M.S., Doorenbos A., Borse N. (2006) Enhancing Cultural Competence Among Hospice Staff. American Journal Of Hospice and Palliative Medicine 23(5) 404-411.	A pilot study to examine change in cultural competence in response to a face-to-face educational intervention aimed at expanding cultural awareness, sensitivity and competence with multidisciplinary hospice workers.	130 hospice workers from 155 employees from 8 hospice agencies	1h educational session about specific populations (not defined), including group discussions.	Quasi-experimental longitudinal cross-over design. Pre-test-post-test	Even a modest intervention improved cultural competence scores.	A short timeline -> further examination needed whether participants truly achieve lasting behavioral changes.	End-of-Life Nursing education Consortium Training Materials Module 5, "Cultural Considerations in the End-of-Life-Care.	The Cultural Competence Assessment tool (CCA)

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Papadopoulos I., Tilki M., Lees S (2004) Promoting cultural competence in healthcare through a re-search-based intervention in the UK. Diversity in Health and social care 1:107-15	To deliver a team-based practice-focused model of educa-tion and training to promote cultural compe-tence	35 members of mental health care staff	Eight session over a four-month period. Lectures and discussions.	Pre-post- self-assessment; agree/disagree questions. Consists of four sections; awareness, knowledge, sensitivi-ty and practice. Also included a visual VAS scale to rate their own cultural competence.	Majority of the participants stayed at the same level of cultural compe-tence, two moved down a level.	Only half of the participants completed the post-intervention assessment --> difficult to draw strong conclu-sions.	Papadopoulos, Tilki & Taylor model	Pre-post-assessment. Self-assessment CCA-Tool, based on the model of Papadopoulos et al (1998).

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Salman, A. McCabe, D. Easter, T. Calla-han, B. Gold-stein, D. Smith, T.D. White, M.T. Fitzpatrick, J.J. (2007) Cultural Competence Among Staff Nurses Who Participated in a Family-Centered Geriatric Care Program. Journal for nurses in staff development. 23(3). 103-111.	To evaluate the effect of ethno-geriatric training program on the nurses cultural awareness and cultural compe-tence	207 Rns from two hospitals in New York. In the first phase, 65 unmatched pairs of RNs were enrolled in the pre-test and post-test groups. In the se-cond phase 142 RNs were recruited for both pre-test and post-test groups	One cultural workshop and five sessions of ethnogeriatric care.	Descriptive explora-tory design, pre-test-post-test, matched pairs, comparison groups, convenience sample	The training had an statistically significant effec-tive in increasing nurses cultural awareness and cultural compe-tence levels	Effects of nurses educa-tional back-ground, years of nursing experience, age and ethnicity on the level of cultural compe-tence were not evaluated in the study. Some nurses in the comparison group had received the training in the phase 1 of the study	Campinha-Bacote	CAS, IAPCC-R

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Taylor-Ritzler T. Balcazar, F. Dimpfl, S. Suarez-Balcazar, Y. Willis, C. Schiff, R. (2008) Cultural competence training with organizations serving people with disabilities from diverse cultural backgrounds. Journal of vocational rehabilitation 29(2). 77-91.	To describe the training approach used by the Center and present data on the impact of training at individual and organizational levels	Twelve trainings were conducted in 2005 and 2006, total of 549 individuals attended to trainings, 287 to the actual study	7 hours designed to increase participants' levels of critical awareness, knowledge about the factors that influence lectures, group discussions, large and small group activities, and an organizational goal-setting exercise	Pre-post, 6 months of follow-along support.	Statistically significant improvements in cultural knowledge at post-test.	Future research should examine the link between staff training in cultural competence and consumer outcomes and satisfaction	Developed their own model.	Two instruments were used to assess participants' satisfaction with the cultural competence training: Cultural Knowledge Assessment the Training Satisfaction Survey Other assessment tools only used at the baseline Measurement Scale from Moffat and Tung for assessing cultural knowledge including 14 true/false statements

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Walton J. 2011) Can a one-hour presentation make an impact on cultural awareness? Neph-rology nursing journal 38(1): 21-31	To assess the effects of an educational intervention in college health science students about Native Americans re-ceiving hemodi-alysis.	95 students from two different colleges.	60-minute presentation, which included PowerPoint ® presentation, a lecture and questions and answers. During the pre-test questionnaire, sweet grass was burned in the room and flute music played from a Native American musi-cian.	Pre-and post- sur-veys. An optional qualitative part included writing a reflection paper related to a case study.	The results demonstrated that there was a statis-tically significant rise in the cultural awareness scores.	Students were mostly Cauca-sian so the study suggests that the result cannot be generalized	-	18-question pre- and post- test, created from the research findings of Walton (2007: *Prayer warriors: A grounded theory study of Ameri-can Indians receiving hemodialysis.)*

Title of the Appendix

Database	Key Words	Hits	Limitations	Articles retrieved	Relevant articles
CINAHL	cultural competence AND training/	419	Linked full text, English language, years 2000-2011	115	6
	Transcultural AND intervention	138	Linked full text, English language, years 2000-2011	30	2
	Immersion AND cultural competence OR study abroad	39	Linked full text, English language, years 2000-2011	13	4
OVID/MEDLINE	cultural competence AND training	218	years 2000-2012/ English language/linked full text	68	2
ERIC	cultural competence AND training AND health care	115	years 2000-2012, English language	2	0